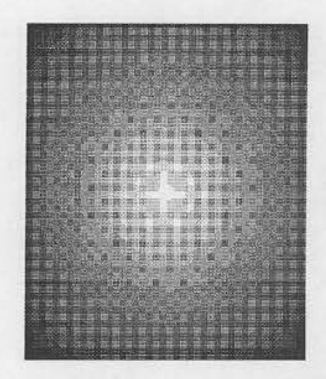
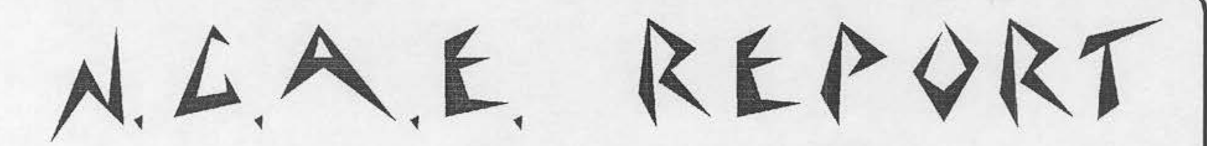


Bulletin of ANOMALOUS Experience

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News from the National Conference on Anomalous Experience, held January 1991 in Chestnut Hill, Pennsylvania

Bulletin of Anomalous Experience is a networking newsletter about the UFO "Abduction" phenomenon and related issues for interested scientists and mental health professionals.

BAE provides a forum for dissemination of information and insights, and ongoing debate. If you have something to say, here is a place to say it. If you have a question or a problem, here is a place to ask for help.

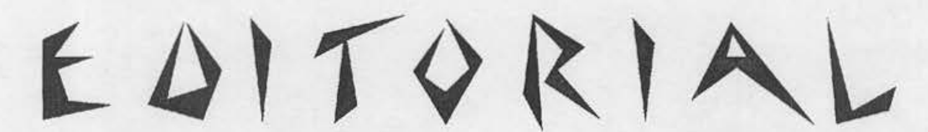
BAE is contribution-driven, and I see my role not as an editor but as a chairman of a series of ongoing, parallel discussions. Editorial comments and introductions are identified by italics.

When you're done with this issue, write me! Tell me what you think of this issue. What topics do you think should be covered? Is there a role for BAE at all? If you prefer to be anonymous, that's perfectly fine. Remember, I know where you all live.

Frequency of publication is nominally bimonthly, but may turn out to be more often if the volume of contributions warrant.

Distribution is limited to mental health professionals and interested scientists. Requests for subscriptions (at $20 per year, a real bargain!) are welcome. (Cash or money orders would be preferred to cheques -- my bank charges big bucks to deal with cheques drawn on U.S. banks.) Write to

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This seems like a good place to acquaint new readers with BAE and to address some comments about BAE made by NCAE participants.

BAE is intended as a networking vehicle for mental health professionals and scientists interested in the UFO abduction phenomenon. It is not a vehicle for my private views, although since I am doing all the work in putting it out, I feel I can exercise a certain discretion in suggesting topics that might be worthwhile addressing (this does NOT mean that I censor contributions on topics that I may not feel relevant).

There were two pieces of constructive criticism presented to me regarding BAE. Both related to my pieces on temporal lobe epilepsy and the possible effects on consciousness of electromagnetic fields. The objections were (a) You don't really believe that has anything to do with abductions, do you? and (b) all that electromagnetic stuff is irrelevant -- it confuses the issue and is impossibly difficult to study anyway.

Assuming there are others out there who have the same questions, I thought I would take some space here to talk about my rationale for including those pieces, as well as featuring other topics that may at first glance appear to be peripheral (at best) or irrelevant (at worst) -- the Spiritual Emergence Network, for instance, or Hilary Evans' Street Lamp Interference Data Exchange.

I have four reasons for including this material:

1. Contributions from the readers were scanty. (See, if you wrote more, you wouldn't have reason to complain!)

2. The true nature of this phenomenon is, in my opinion, far from conclusively proven. There are still many different schools of thought (physical, sociocultural, and imaginal, to name a few). Rather than adhere to one particular theory, I am trying to promote an open-minded consideration of all hypotheses and all potentially relevant evidence.

One big problem in this field, in my opinion, is the isolation of different camps. For instance, I am not aware of much interaction and sharing of data between investigators who believe abductions to be positive experiences, and those who believe it to be traumatic. (Correct me if I'm wrong, anybody out there!). The diversity of ideas in BAE is an attempt to rectify that.

Nothing here is presented with an endorsement; rather, as ideas, observations, hypotheses and opinions to stimulate your thinking.

3. I have observed, along with a number of others, some phenomena in the abductee population that are also seen in other kinds of anomalous experiences. For instance: Interference with electrical equipment; out of body experiences; spontaneous cures; 'psychic' abilities. Since we do not understand much about these phenomena either, it seems like a good idea to be aware of the work being done in these areas.

4. If you think the ideas in question are dopey, at least after reading about it you are better equipped to humiliate anyone advocating that position.



Introduction

This issue is a report from the first National Conference on Anomalous Experience, held January 18-20 in Chestnut Hill, Pennsylvania. THe conference was organized by Dave Jacobs and Budd Hopkins as an information-sharing and brainstorming session on UFO abductions.

The meetings ran from Friday evening to Sunday noon. It was one of the best conferences on the subject I have ever attended. THere was a minimum of formal presentation time; most of the sessions consisted of lively debate among the participants. Michael Swords did an excellent job moderating the discussion, and making sure that all attendees had an opportunity to voice their ideas.

There were just over 40 attendees, including 2 sociologists, 3 psychologists, and 9 physicians. This was the first clinically-oriented conference to my knowledge with a session devoted to abductees telling their side of the story. This abductee panel was both informative and moving.,

Many of the attendees were interested in participating in BAE, and I hope the collegiality and spirit of inquiry that was so intense at Chestnut Hill will continue in these pages.

Not all comments or ideas presented here have a name attached to them, because some participants expressed, directly or indirectly, a concern about their involvement with this issue becoming too well-known. I have exercised some discretion in this area. Also, any errors or omissions are my own fault, so please feel free to correct me.

Phenomenology

- Dave Jacobs presented his model of the phenomenology of abductions. This model is summarized in the chart below. Procedures focus on three areas (physical, mental, and reproductive systems). Within each area, there are primary events (which happen to almost every abductee), secondary events (which do not occur in every case), and ancillary (or infrequently seen) events. His observations are summarized in Table 1.

- For eliciting information on "imaging" (secondary mental event), Dave recommends asking where the being is standing, what he is doing, and where he is looking; the subject will usually tell you that the being is staring into his or her eyes.

- The frequent description of animals appearing in inappropriate settings during abduction experiences was noted by a number of therapists. These "animals" do not behave normally, and upon further recall or questioning it appears that they are really "greys." As an example of this, one patient of mine reported encountering three horses on a country road just before an abduction experience. Asked to draw them, he drew outlines that looked nothing like horses, but just like three "greys." When I pointed out to him that they looked nothing like horses, he acknowledged this and expressed much confusion that he was so certain they were horses. Hypnotic regression confirmed that they were "greys."

- Initial signals or herald signals were discussed. These are auditory or visual cues that regularly appear to the experiencer just before an abduction event is to occur. Examples of herald signals mentioned were: A series of flashing lights, a series of 3-6 musical tones, verbal suggestions, raps/knocks, high-pitched noises (not audible to others).

During the interview or regression, it is important to ask the experiencer what they are hearing, and when (eg before the paralysis of an abduction), or you may miss it. One individual will tend to experience the same signal, and different people tend to have different signals.

One researcher noted the frequent occurrence in child experiencers of repetitive buzzing in the ear. She asked these children to attempt to reproduce the sound, and observed similarities in pitch and range among the signals produced by different children.

A participant pointed out the similarity between these herald signals and temporal lobe epilepsy prodromes.

- Dave Jacobs noted that in his case group, most experiencers have had childhood abductions. He says he rarely sees "adult-onset" abductees unless their abduction was "opportunistic" (i.e they were taken with another childhood-onset abductee).

	Primary	**Secondary**	**Ancillary**
Physical	*Examination* Tissue samples Implants (nose/ears/sinus cavities most common sites)	*Machine* Enveloping Scanning Light Misc.	*Misc. Physical* Surgery Pool Cures Pain
Mental	*Staring* Onset Calmative phase End-painful Sexual arousal Mindscan (being is very close to subject when this occurs) "Bonding"	*Visualization* Imaging (eg on a screen) Envisioning (played out in subject's mind) Staring (subject participates in a scene) Testing (given tasks to do)	*Misc. Mental* Media display (often of a pastoral scene) Knowledge Trips Info. transfer (sometimes thru attached wires)
Reproductive	*Uro-Gyn* Egg/sperm collection Embryo implantation Fetal extraction	*Child Presentation* (usually involves holding or hugging) Incubatorium Nursery Baby Toddler-Youth Adolescent	*Sexual Activity* Involuntary/Compulsive With humans With aliens or hybrids

Table 1: Dave Jacobs' Classification of Abduction Procedures

Hypnosis Techniques

- Budd Hopkins recommends that when faced with a block in the regression because of fear, to suggest to the subject that "I don't want you to look (at the feared object/event); close your eyes; we'll go through your body and see how it feels." Start with the feet and slowly work up, asking the subject to pay attention to whether the site in question has normal sensation or unusual sensations. If the subject detects an anomaly, spend some time here, and when the subject is ready, ask if he feels like opening his eyes just a crack..."

- Dick Haines presented his Three Stage Technique for using hypnosis to investigate abductions:

First Pass: After inducing a trance, request the subject to describe "everything you see, hear and feel." The therapist is then completely silent until the subject is finished.

Still in hypnosis, the second pass begins. The therapist brings the subject back to the beginning of the experience, and adds to the previous instructions a suggestion to describe "what you say out loud, and all you think and feel."

When this regression is complete, leave them in hypnosis but let them rest for a while. In the third pass (still studying the same experience as in the first and second passes), the subject is told that "we will go thru the experience together, side by side." The therapist may ask questions as the subject relives the experience for a third time.

- Dave Jacobs was challenged on how he determines what details in a subject's hypnotic regression is confabulation and what is accurate experience. Dave said that he felt details became more reliable in subsequent regressions, and that "through experience, trial and error, and repetition" the investigator would be able to distinguish one from the other.

- Ron Westrum pointed out that forensic literature on conscious recall of memories suggests the contrary, i.e. that the original narrative tends to be the most accurate.

Dick Haines feels that the first narrative of the three in his three-stage technique is the most reliable, and that by asking questions of any kind the therapist is likely to alter the memory. There remains an unquantified danger that by questioning the hypnotized subject, and by repeeated regressions, the investigator may be inadvertently accentuating the patterns he is looking for.

This issue deserves further study.

- Dick Haines says in his office, he uses two microphones to record his regression sessions. One microphone is placed on the vocal cords, and the other is placed in the usual manner. Using this method, and recording from both microphones on a stero recorder, he has observed subvocalizations preceding the vocalized response. These subvocalizations are opposite in meaning to the verbalizations; for instance, the subject might be heard to subvocalize "no" and verbalize "yes" immediately afterwards.

Working With Children

- Budd Hopkins suggests the following projective test in interviewing children. He has a set of portrait sketches prepared, consisting of (in order) Santa Claus, Batman, a clown, a policeman, an adult female, a Ninja Turtle (Leonardo, I think), an ET (a la COMMUNION cover), a young boy, a witch, and a skull.

He asks the child to identify each picture. Abductee children will often respond with significant distress upon seeing the ET.

The next step is to ask the child to sort the pictures into good people and bad people. After that, the child is presented with two portraits (one control, and the ET picture), and asked to make up a story about each, perhaps with the premise that the character visits the child in his room.

- E.Z. Brenham uses hand puppets of conventional, nonthreatening characters to allow his child abductees to describe their experience in a role-playing setting. He says this gives the children a sense of control: For instance, they can choose in their role-playing game not to go off with the visitor puppet. This technique also allows them to talk about their feelings without expressing them directly.

- The isolation abductees experience following the initial trauma is especially difficult for children to deal with. The value of inter-generational talk (between parents and kids) in alleviating this problem was stressed. Parents should not, however, tell their kids that the abduction incident was a "dream" (which the children know not to be true), or that the parents can protect the kids. The child knows this is beyond the parent's capability. An analogy was drawn to parents reassuring kids falsely about nuclear war threat -- the children often reply that "you don't really love me if you say that."

- Asked but not answered: "How often do kids refer to the visitors using the word 'aliens?' "

Interventions

Two basic strategies for helping the experiencer to cope with continued abductions were presented.

- INTERRUPTING AN ABDUCTION.

1. E.Z. Brenham spoke in detail about giving a Post-Hypnotic Suggestion (after conscious consultation with the subject) that he will only be able to be hypnotized by particular people (who the therapist names). The subject will not be responsive to any hypnotic or telepathic stimuli presented by anyone else. The therapist should be part of the list of names, of course.

In the case of herald signals, post-hypnotic suggestions are given to (a) make the subject unresponsive to them, or (b) make the subject hyperalert and conscious in response to them.

2. Another approach is to suggest to the subject that their unconscious produce a "white noise" or "electrical storm" sound to seve as interference to prevent perception of the herald signal or telepathic commands. This is particularly helpful when the subject is sleeping, or when busy with some task.

3. Pain and Anger. These are useful in interrupting the terror often associated with abductions. In an incident involving Ed Walters (of Gulf Breeze fame) described to the group, Ed interrupted the mental lock during an abduction when he accidentally bit his tongue. He attempted to flee but the ETs responded by placing an image in his head of his child being abducted. The abduction event was allowed to continue. Thus pain seems to be effective in forcing a shift in the subject's consciousness. Anger also works for some subjects.

3. A Whack on the Side of the Head. Another story was told of a subject who managed to become awake during an abduction in her bedroom. She spontaneously took a whack at the ETs and connected with the head of one of them. Its head snapped backwards and she believed she had broken its neck. At that point the other ETs ignored her and carried their comrade away. The abduction event was terminated. There was no apparent retribution. (Presumably these ETs have Blue Cross).

It was noted that using the posthypnotic suggestion to block herald signals can often lead to new signals, not responsive to the post-hypnotic suggestion, being used in place of the old, neutralized, ones. Also noted are implanted thoughts to the effect that "It's not going to work -- we can take you anytime we want you."

Just how this technique works is unclear. It was suggested that by shifting the subject's state of consciousness into an alert or hyperalert state makes him "too much bother" for the ET, and they prefer to go looking for an easier target.

The success rate, and side effects, of this approach are not known. It is also not known if this technique simply suppresses conscious recognition of abductions that continue to occur. Also, abductions occur at irregular intervals, so a cessation of abduction events may be part of this irregularity and have nothing to do with the intervention.

- MASTERY OVER THE EXPERIENCE.

1. Investigator & Experiencer as a Team. Respectfully including the subject as a "co-investigator," and suggesting that collecting further information on his experiences, although uncomfortable, is a process important to human science and understanding. This approach was suggested to have a therapeutic mastery element, and was compared to similar mastery effects produced through the Alcoholics Anonymous 12-step program.

2. A Common "SEND" Message. Dick Haines suggests giving abductees a sense of control by giving them a simple task to concentrate on during an abduction. Specifically, he suggests investigators as a group agree on a common message that abductees would attempt to communicate to visiting ETs. Abductees would also be attentive for a reply. This involves the subject in the research "team," and may produce some interesting results if the responses received from abductees working with different investigators have some concordance.

3. Remember the Event. John Miller gives abductees a post-hypnotic suggestion that if another abduction does occur, the subject will be able to remember the events clearly and consciously. This addresses a common frustration that abductees voiced in the panel discussion: That their recall of abduction details is often vague and incomplete.

Therapeutic Issues

- Scientist / Therapist: Is the primary responsibility of the therapist to get the abductions to stop (or to help them deal with the experiences), or is it information retrieval. The consensus was the former.

Notwithstanding that, clinical treatment can be of use to the scientist in three ways: (1) Results of treatment; (2) Case studies; (3) Overviews of the phenomenon.

John Carpenter deals with the scientist/therapist dichotomy by working with an investigator assistant. This person asks no questions, but observes and documents. She suggests questions and directions for the therapist to take, but it is the therapist who has final say and control in dealing with the experiencer.

- MUFON Complaints. Some therapists described problems with MUFON investigators who appeared to follow agendas in which collection of information took priority over the needs and well-being of the experiencer. Walt Andrus of MUFON assured us that he is aware of these problems, and is taking steps to correct them. One change in MUFON is the rewriting of the field investigator's manual to stress teamwork and screening in determining if the subject requires referral, and if hypnosis is to be used.

- Code of Ethics. Dick Haines suggested that a code of ethics, and a form of self-policing to enforce it, is necessary. If we do not implement such a policy, he warns that we may find someone doing it for us. *(For an example of such a code of ethics, see the first issue of BAE -- then called "Ratchet Patrol").*

Implants

A general discussion of a scientific approach to the analysis of implants was presented, followed by three investigators' studies of recovered implants.

- A Scientific Approach to Implant Analysis.

The analysis of a physical artifact such as an implant requires study of the pedigree of the artifact, as well as a physical analysis.

Defining the pedigree of an artifact requires documenting the following:

1. The story (alleged history): Description of the origin of the artifact, and the circumstances surrounding its recovery. A documented description of the item BEFORE recovery is very important.

2. The reliability of the story: Study independent corroboration, ancillary evidence, witness credibility, similarity to independent accounts.

3. Temporal elements: How does the story change over the course of the investigation, especially after discovery of artifact.

Physical aspects of the implant that would argue for alien origin are:

1. Performance: Does the item display performance characteristics not known on earth (eg high tensile strength for its diameter). This is the best argument of all, and can be convincing even with simple characteristics.

2. Composition: Demonstration of superheavy nuclei or strange matter, neither of which is known to exist on earth. Another criterion is isotope ratios, eg ratio of Carbon-13 to Carbon-12; but discovery of a ratio that is not biologically produced is not conclusive evidence either, as this ratio could be produced by manufacturing processes known on earth.

3. Structure: Study the item at the level of atoms, molecules, polymers/macromolecules. This approach is less likely to convince people the higher you go, because there are already many terrestrial objects with strange or unfamiliar microstructures.

Arguments based on performance can be compelling, while arguments based largely on composition and/or structure are not likely to be persuasive.

- Implant #1

This object was a penile implant recently recovered from an abductee, who recalls that it was put in place in September 1955, when he was 8 years old.

The entire implant was less than 1 mm long. There were numerous fine appendages attached to the object, which attracted the most interest in the analysis. These appendages appeared flat, noodle-shaped under the scanning electron microscope. Opinion was split as to whether it resembled linguine or fettucine. The appendages ended with up to three small hooklike structures.

Summary of physical characteristics of these appendages:

1. Length: .2 to 1.00 um
2. Diameter: 18 plus/minus 3 u
3. Oval cross section 1:2 or so, twisted
4. Color: translucent, yellow-brown, some red
5. Texture: lines and specules 2-3 u
6. Structure ends: finer texture, red reflection

These characteristics were compared against a standard text on materials: The best match was for dust cotton, but this material only corresponded to our artifact on the first five points.

An elemental analysis showed carbon and oxygen present; nitrogen present at less than 1%.

Conclusion: Unable to demonstrate alien origin.

• Implant #2

This implant was retrieved and examined by a pathologist. It was removed two weeks from the time it was first noticed by the experiencer. Site of retrieval was 3-4 mm behind the corona (head) of the penis in a circumcised male. It was observed to be oriented circumferentially (which is anatomically unusual), on the dorsum of the penis. On palpation, it was estimated to be 8 mm x 0.5 mm (diameter), firm, pliable, and wire-like.

An incision was made 1/2 to 3/4 cm below the skin, and a small portion of the object was excised. After removing this portion, the investigator returned to the site to extract the rest, but despite persistent probing (producing a large hematoma) he could not find the rest of the artifact.

Microscopic slides were made of this sample, and the following observations were made:

-No inflammatory reaction, or giant cell formation was observed. This is unusual, because both would be expected with the presence of a foreign body of any known kind.

-An occlusive area in the lumen of an artery was observed. This area was well-formed, with an unusual fibrosis pattern and without inflammatory changes.

-Hyalinization changes within the wall of the same artery was seen, suggesting an event of long standing, not one two weeks old.

-Some mucinous change without evidence of inflammation was seen. This mucinous change is usually only seen in tumours.

-Few areas of foreign bodies were seen. One area of foreign body was reminiscent of Implant #1 above, but no inflammatory reaction was noted around it.

-Abnormal deposition of elastic fibers in the thrombus area was noted.

Conclusion: Inconclusive. More work needs to be done. There is something unusual about this specimen, but the investigator is not sure how to explain it.

This investigator, who has also studied the pathology of cattle mutilations, says there are no similarities between that phenomenon and this implant study. In particular, the trauma, scarring, heat effect and basophilia seen in cattle mutilations were not observed here.

• Implant #3

This item was studied by a molecular biologist. The implant was coughed up from the back of the throat the morning after an abduction event.

The item was described as being 1 cm long, 60 microns in diameter, wiry and pinkish-hued. Under the scanning electron microscope, it was flat and thin (reminiscent of pasta, like implant #1), with a trilobed structure. These lobes had a striated or braided texture.

Elemental analysis: 65% Carbon, 25% Oxygen, 10% Aluminum.

Conclusion: Not sure what to make of it.

• Recommendations

In discussing these results, it was suggested that rather than have individual investigators spend lots of time and money doing tests of properties that may lead nowhere, we would be better off accumulating these items, and make comparisons among them.

Also, a committtee consisting of professionals in all areas of analytic science would be needed to decide how to deal with these artifacts without destroying them.

It was also pointed out that an exhaustive analysis of any one implant would be extremely expensive.

One person wondered if these items, rather than being implants, were artifacts of an implant procedure ("like leaving a sponge in the patient").

Incidentally, none of these three implants was visible on Xray.

Abductee Panel

On Saturday night a panel of eight abductees, most of whom had worked with Budd or Dave, shared with us their insights on their experiences. Here are the highlights:

• Experiences Before Being Identified As An Abductee

-Many felt they were hiding something -- that they and their family were different from other people. This was experienced as a vague, unresolved and unidentifiable problem. For the most part, this resolved after treatment, though one person admitted to still having some intellectual difficulty in accepting the abductions. -"I spent my whole life suppressing things that I knew, and the way I saw things. I felt I was playing dumb."

-Before being identified as abductees, some were "clueless" (had no suspicions or ideas about this). Others felt they were aware of being under instructions by "THEM" not to tell anyone about their experiences.

-Some felt a sense of mission/purpose/being given knowledge but able to recall it consciously only in "time-release" fashion.

-One related meeting a stranger on the street, who told them personal details, that they are 'on a mission,' and correctly predicted events that happened to them in near future.

-The "A-Ha" experience appeared to be common: Hearing a story or seeing an ET sketch, and feeling of intense familiarity and rapport.

-"You cannot control it. If THEY want it (an abduction) to happen, it'll happen."

- Reflections On Their Therapy

-"I am a much better person for having undergone hypnosis...and having gotten this out of the way." (This person works with abductees now).

-After treatment, some felt less of a need to "perform" or act "in ways people expect you to."

-The panel reported variable resolution of symptoms (mostly anxiety) that were present before treatment. One person experienced complete resolution of her panic attacks. Some had no symptoms before their abductions were identified, and some who had anxiety before still have it (appropriately so, because their abductions continue to occur).

-Support groups were felt to be helpful in providing an understanding and accepting community.

-Asked to recount their most helpful or effective moment in therapy: "To be received as an equal--accepted, respected;"

"Going through regressions, clarifying 'dreams';"

another said it was their therapist (not familiar with abductions) being open-minded about the possibility of abductions, and making a referral, instead of thinking she was crazy.

-Asked to describe their least helpful or most horrible moment in therapy: "A feeling that the (therapist's) meter was running."

This person highlighted the confusion he felt: Was he a subject in the therapist's research (in which case the therapist should reimburse him) or a patient (in which case he should reimburse the therapist). The abductees want to know about their experience, but resent doing it in the role of a "patient." He saw his experience as a challenge in his life he wanted to meet, not as an illness to be treated.

- How Their Experience Affects Them Today

-"How do you live your life when you have been exposed to a reality that makes a mockery of everything that we are supposed to consider important?"

-"I still cannot talk about this... I must keep it secret... (significant problems in social and business relationships would occur if this came out)... it's a good way to find out who your real friends are."

-Family acceptance is important, yet sometimes elusive or impossible to achieve. When an open dialogue, understanding and sympathy from their families are not possible, the abductees suffer greatly.

-"With treatment, I have come to accept that I am not defective. I know things, I have perceptions that others can't handle. But it does not mean that there's something wrong with me. Now I am not struggling with my own pathology, but someone else's."

-These days some feel as if their mission is to act as "experience collectors/cameras/windows" for the ETs.

-Descriptions of the relationship between the abductee and a special ET: "Student/mentor;" "draftee/drill sergeant."

- What Issues Are Important To Them Now?

-"How much we still don't know about it." Open dialogue among those in the field was important to this person.

-"I have an immense curiosity...I want to get hard data, get a remembered conversation."

-"I'd like to be able to go to work and say, 'Leave me alone, I was abducted last night.'"

- Advice To Us

-"Unless you've been there, you have no idea what we go through."

-In answer to the question, "How do you feel about being treated as 'data'?" opinion was split. Some felt anger ("I don't feel like a phenomenon, but like a victim of a phenomenon"), while others felt a desire to cooperate in investigations ("I want to know the truth, and as much about this as I can.")

-When asked how we should interview "ordinary people" to determine the prevalence of abductions, they suggested that symptom reporting would elicit more response than pursuing abduction memories directly. They also suggested that the active participation of abductees in preparing a survey would be helpful.

-Advice on how the therapist should counsel abductees was split between resisting and attempting to get control, on the one hand, and going with the flow on the other. In the former camp, one abductee says he will "always resist" ("There are many things I would negotiate on, but personal liberties are not a point of negotiation"). A representative of the latter opinion feels resistance is useless; he wants "courage and clarity" rather than being fearful or angry. He felt there was more likelihood of an information exchange, and less likelihood of a traumatic experience, the more relaxed he was.

-None were aware of any way to obtain information directly (and "not come away empty-handed").

Future Directions

• Determining Prevalence

Sunday morning's festivities were led off by the announcement of a $200,000 grant to help determine extent of the phenomenon, and increase public and academic awareness and support. This produced a long discussion about just how we should survey people (and which populations to survey). The following ideas were tossed out for consideration:

-Should we survey the general population, or an area of the country, or one or more particular communities? Should we consider target groups, like Alcoholics Anonymous, or patients presenting to psychiatrists and anxiety/phobic/depression clinics?

-The poll should be done by an experienced professional polling organization.

-Development of a survey is a many-stage process, with full release the very last step. We should use focus groups and pretests to refine the questionnaire.

-Test the survey on people you THINK might be abductees, and use these results to modify the survey before using on the general population.

-Should we conduct the survey under the auspices of a university, rather than have it administered by CUFOS or IF, which might bias attitudes towards it?

-We want to find people before they are identified as abductees. From the panel's observations, this could be very difficult, because many were not aware of the significance of memories such as missing time, bedroom visitors, or episodes of going missing as a child. They would have responded negatively to such questions during much of their life, thus producing a falsely low prevalence result.

-A question to ask: Do you have a very disturbing memory that stayed with you whether or not you understand it? Have you attached an emotional weight to an incident you regard as trivial or frivolous?

-Even if we get an accurate prevalence estimate, what real value does it have, beyond making us feel good?

• Strategy

-"Science can be thought of as a sociological system for convincing a high percentage of people of something. If it's very good science, the general public is convinced... Science evolves by (1) Overwhelming evidence (rare), or (2) (more commonly) Those who do research on the "edge" push just a little further."

-"Focus on questions that are easier to solve scientifically. A good scientist needs to sense what questions to work on that will be most productive."

-Ron Westrum suggested paralleling our strategy to that of early child abuse workers. They knew the extent of the problem, but suppressed much of their knowledge in the initial stages, because they felt it would not be accepted or believed. Instead, they focussed on the peripheral feature of the patterns of physical abuse. In time, more people looked into these patients, and the core concept of child abuse was accepted.

-Following Ron's model, I talked about my approach. I have been successful in interesting skeptical psychiatrists in this field by presenting it as a variant on Post-Traumatic Stress Disorder.

• Issuing a Request For Proposal

A request for proposal (such as National Science Foundation RFPs) would be helpful in many ways. It would identify new talent; summarize existing knowledge; help us clarify our goals; produce new suggestions on how to achieve those goals. Peer reviews of grant proposals also are helpful for the constructive criticism they generate.

• Publish!

Most of the important data in the abduction field is unpublished. This was suggested to be a major drawback in seeking acceptance, and should be remedied as soon as possible by writing up our research data in a professional manner. This way we can reference published data rather than unpublished data. Multi-authored research projects will allow authors to "share the heat." On the other hand, the more papers that are published, the greater the number of citations that can be made.

There is a need for academics, who are familiar with publishing these kind of papers, to work with the clinicians, who have the data. The approach that is seen to be most useful: "I see a syndrome that is new, does not fit any existing paradigm, and is of interest to the clinical community."

Existing databases and raw data to be entered into those datbases should be studied to discover correlations.

The editor of the American Journal of Psychiatry was queried about what would be necessary to publish a paper on this topic in his journal. He suggested a description of a new syndrome by several mental health professionals describing their cases in terms of criteria for inclusion, number of cases, and anecdotal details.

• Disappearing Pregnancies

These cases were mentioned briefly. Though spectacular if they can be documented, they are very hard to document convincingly. Also, disappearing pregnancy is a significant personal tragedy for the couple involved, and it may be very hard for the investigator or therapist to ask for medical records and tests. Even if you have them, the patient may not want this information to be made public.

• Debunking the Lawson Argument

Walt Andrus feels we need to put to rest the "Lawson Argument," referring to a study where abductees and non-abductees were hypnotized and leading questions were used to produce abduction memories from both. The conclusion, widely cited in skeptical literature, was

that abductions are artifacts of the hypnotic process and not genuine experiences.

• <u>Our Weaknesses</u>

-Michael Swords, concerned that some of our clinical data is biased, pointed to the problem of "research filtration," in which the researcher/therapist/invesigator may ignore abduction cases that do not meet his criteria. We need to be able to eliminate such bias where present, and also to demonstrate the absence of bias where appropriate.

-It was pointed out that "we never talk about our rejection criteria for cases."



For me, the weekend was quite stimulating and thoroughly enjoyable. The emphasis on exchange of experiences and opinions, rather than on formal presentations, was particularly appreciated. The sense of camaraderie and common purpose was quite pleasant.

There were some weak aspects to the conference, though. In particular, there seemed to be little challenging of people's ideas and assumptions. One participant called it the "least scientific meeting" he had been to all year. Dissenting viewpoints were often just acknowledged and then not addressed. For instance, there seemed to be a tacit acceptance of Budd and Dave's interpretation of the phenomenon (that ETs are real; the abduction experience should be taken literally; and that this is fundamentally a traumatic experience, with any personal spiritual growth incidental and possibly reflecting a suppression of the traumatic feelings).

I'm not sure if this was because people were uncomfortable challenging the premise of the hosts, or because there were no representatives of alternatives viewpoints in this regard. This did not bother me too much, because within the assumptions governing the meeting, the discussion and criticism was quite freewheeling. I suppose it will be a sign of the maturation of this field that future conferences will have more critical discussion. I hope so, anyway.

I feel most of us left with a conviction that this is an important issue, both clinically (in terms of those abductees that are traumatized) and scientifically. We also left with a deep empathy with those touched by this phenomenon, and a sense of collegiality and mutual support among the professionals, and the abductees, present.

I congratulate Budd and Dave for the concept and organization; Michael Swords for running the discussions so effectively; and our benefactors for making it all possible.

